California Small Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change Form

Applicant's Social Security Number

Employer Name	**INSTRUCTIONS:** You, the employee, must complete this enrollment form in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness. **If waiving coverage, please complete Sections B and D.**

Effective Date / **Date of Hire**	☐ New Group Enrollment ☐ Late Enrollment ☐ New Hire ☐ Other _____ ☐ Rehire/Reinstatement	☐ Add Spouse/Dependent Child ☐ Change of Coverage ☐ Name Change ☐ Other _____	☐ Employee Termination ☐ Remove Spouse/Dependent Child ☐ Cancel Coverage	COBRA / Cal-COBRA for: ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 ☐ 36 ☐ Other _____ Original Qualifying Event _____ Date _____

A. Coverage Selection - *Please print clearly, using black ink.* *(Shaded sections for Employer/Aetna Use Only)*

Control/Group No.	Suffix	Account	Plan No.	Class Code	Control/Group No.	Suffix	Account	Plan No.	Control/Group No.	Suffix	Account	Plan No.

1. Medical - Check one.

☐ HMO: ☐ $10/$10 ☐ $10/$30 ☐ $30/$40 ☐ $15/$15 ☐ $20/$40
☐ EPO
☐ MC: ☐ $0 90/70 ☐ $250 80/60 ☐ $500 70/50 ☐ $0 90/60 ☐ $500 80/60 ☐ $1,000 80/50 ☐ Basic ☐ MC HDHP $2,100 100/50 (HSA Compatible) ☐ MC HDHP $3,000 90/50 (HSA Compatible) ☐ MC HDHP $5,000 100/50 (HSA Compatible)
☐ PPO: ☐ $250 90/70 ☐ $500 80/60

2. Dental - Check one (if applicable).

☐ DMO 1 ☐ PPO 1 ☐ PPO 3
☐ DMO 2 ☐ PPO 2 ☐ PPO 4
☐ Freedom-of-Choice 1: ☐ DMO *or* ☐ PPO
☐ Freedom-of-Choice 2: ☐ DMO *or* ☐ PPO
☐ Out-of-State

Before today, were you covered under this employer's dental plan? ☐ Yes ☐ No

☐ Aetna Indemnity
☐ Out-of-State PPO (choose one): ☐ $250 ☐ $500 ☐ $1,000
☐ Traditional Choice

3. Life

☐ Basic Life / AD&D Ultra™
☐ Optional Dependent Life

Beneficiary Designation - **Full Name** (First, Middle, Last)

Beneficiary Social Security No.	Relationship to Employee

B. Employee Information - *Must be completed by the employee.*

Member Aetna ID Number (if available)	Last Name, First Name, M.I.	Job Title	Home Telephone	Primary Language Spoken Optional

Home Address	Apt. No.	City, State	ZIP Code

Work Address	City, State	ZIP Code	Work Telephone

Salary (required) $ ☐ Hourly ☐ Weekly ☐ Monthly	No. of Hours Worked Per Week	Check One ☐ Part-time ☐ Full-time	Marital Status ☐ Married ☐ Single	No. of Dependents Including Spouse

C. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary.*

NOTE: Enter Domestic Partner ONLY if your employer has elected that coverage.

(A)dd (C)hange (R)emove	Name (Last, First, M.I.)	Sex M/F	Social Security No.	Birthdate MM / DD / YYYY	Height (ft., in.)	Weight (lbs.)	Incapacitated	Coverage Election	Other Health Coverage	Other Dental Coverage	Student Age 19 or Older	Primary Office Number (If applicable)	Current Patient	Dental Office ID Number (If applicable)	Current Patient
	Employee **1.**			/ /			Yes N/A	☐ Medical ☐ Dental	Yes ☐	Yes ☐	Yes N/A		Yes ☐		Yes ☐
	Spouse/Domestic Partner **2.**			/ /			N/A	☐ Medical ☐ Dental	☐	☐	N/A		☐		☐
	Child **3.**			/ /			☐	☐ Medical ☐ Dental	☐	☐	☐		☐		☐
	Child **4.**			/ /			☐	☐ Medical ☐ Dental	☐	☐	☐		☐		☐

D. Declination/Waiver of Coverage - *To be completed if medical and/or dental coverage is declined or refused by an eligible employee and/or their eligible family members.*

1. Medical Coverage Declined for: ☐ Myself ☐ Spouse ☐ Dependents
2. Dental Coverage Declined for: ☐ Myself ☐ Spouse ☐ Dependents
3. Life Coverage Declined for: ☐ Myself ☐ Spouse ☐ Dependents

Reason for Declining Coverage *(If applicable, please attach front/back of your health coverage ID card.)*:

☐ Covered by spouse's group coverage - Carrier Name and ID Number: _____
☐ Enrolled in other Insurance Carrier Plans - Carrier Name and ID Number: _____
☐ Spouse covered by employer's group medical coverage ☐ Spouse covered by employer's group dental coverage
☐ Medicare ☐ Covered by Champus or Champva ☐ Other (Explain): _____

I acknowledge I have been given the right to apply for this coverage, however, I am electing not to enroll. By declining this group coverage I acknowledge that myself and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage. Pre-existing conditions, when enrolled in this plan, may not be covered for six months.

Please sign here ONLY if you are declining coverage for yourself or dependent(s). X	***Date (Month / Day / Year)***

E. Dependent Information

Does any dependent listed in Section C live at another address? If Yes, who and what address? ☐ Yes ☐ No	If any dependent's last name differs from yours, explain the circumstances.

After completion, sign, remove tape from inside pages, fold closed and press to seal, and submit to your employer.

F. Other Insurance

If you have checked "Yes" to Other **Health** Coverage in Section C (including Medicare benefits), provide name and policy number of insurance carrier, HMO, or other source, a copy of the insurance card or Medicare card and start date of the coverage.

If you have checked "Yes" to Other **Dental** Coverage (Section C), provide name and policy number of insurance carrier, HMO, or other source, a copy of the insurance card and start date of the coverage.

Is your Spouse employed? If "Yes," provide name and address of spouse's employer.
☐ Yes ☐ No

PROOF OF PRIOR COVERAGE - IMPORTANT (*Required*)

Does anyone enrolling on this enrollment form have prior coverage?
☐ Yes ☐ No

If you answered "yes", provide applicant names, start and end dates of prior coverage.

_____

_____

Proof of coverage must accompany this enrollment form for pre-existing condition credit.

Acceptable forms of proof are:

1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member to the full pre-existing conditions limitation with no credit for prior coverage. You may request a Certificate of Creditable Coverage from your prior carrier.

G. Health Questionnaire for Groups Enrolling 2 - 10 Employees

Health History for Individuals and Their Dependents. ***The following information is confidential and will not be seen by or given to your employer.***

- ALL of the questions must be answered by you and your dependents or the enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

In the past five (5) years, has any person listed on the enrollment form seen a health care provider(s), had treatment recommended, received treatment, including prescription medications or been hospitalized for any of the following conditions listed below?

		Yes	No
1.	Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins or other disorders of the heart, blood (except HIV infection), blood vessels or high cholesterol?	☐	☐
2.	Ulcer, colitis, gallstones or any other disorder of the stomach, intestines, rectum, pancreas, liver or Hepatitis B or C?	☐	☐
3.	Cancer, cyst or tumor?	☐	☐
4.	Disorders of the kidneys, adrenal glands, thyroid glands, urinary systems, male or female organs, infertility, menstrual dysfunction or sexually transmitted disease?	☐	☐
5.	Asthma, emphysema, tuberculosis or any other disorders of the lungs or respiratory system?	☐	☐
6.	Migraines, fainting spells, epilepsy, mental or nervous conditions, depression, paralysis or any disorder of the brain or nervous system? If epileptic, date of last seizure: ____/____/____ (month/day/year)	☐	☐
7.	Lupus, arthritis, back trouble or any other disorder of the joints, muscles or bones, including prosthetic device or implants?	☐	☐
8.	Any physical deformity, defect or congenital problem?	☐	☐
9.	Has any person to be covered had or has been told that they have an immune deficiency disorder (except HIV), AIDS, or AIDS-related complex?	☐	☐
10.	Has any person been treated for alcoholism, other drug or substance abuse, including use of any illegal or controlled drugs, or been advised to seek treatment for the same?	☐	☐
11.	Has any person been diagnosed with diabetes? If yes, list date of diagnosis: ____/____/____ (month/day/year) Insulin dependent? _____ Non-insulin dependent? _____	☐	☐
12.	a. Is any female to be covered currently pregnant? If yes, list due date: ____/____/____ (month/day/year)	☐	☐
	b. Have there been any complications thus far?	☐	☐
	c. Are multiple births expected?	☐	☐
	d. If you are a male listed on this enrollment form, are you expecting a child with anyone, even if the mother is not listed on this enrollment form?	☐	☐
13.	Has any applicant taken any prescribed medications in the past 12 months? **If yes, list below**.	☐	☐
14.	Has any applicant had an abnormal physical exam or been advised to undergo further testing, surgery or treatment?	☐	☐
15.	Has any applicant been a patient in a hospital, clinic, surgical center, sanatorium or medical facility as an outpatient or inpatient (excluding childbirth)?	☐	☐
16.	Does anyone named on this enrollment form use tobacco products, including cigarette, pipe, cigar, or chewing tobacco?	☐	☐
17.	Has any applicant had any medical condition or symptom not listed on this enrollment form?	☐	☐

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE SECTION I ON THE FOLLOWING PAGE.

If you are providing additional sheets, check here ☐ and insert the sheets before sealing this Enrollment form.

H. Health Questionnaire for Groups Enrolling 11 - 50 Employees

Health History for Individuals and Their Dependents. ***The following information is confidential and will not be seen by or given to your employer.***

- ALL of the questions must be answered by you and your dependents or the enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

In the past five (5) years, have you, your spouse or any of your dependents:	**Yes**	**No**
1. Had, consulted for, had treatment rendered, been advised to have treatment or been hospitalized for any of the following: Cardiovascular disease or heart attack, stroke; disorder of the kidneys, stomach, intestines or liver; musculoskeletal conditions; mental or nervous condition; central nervous system disorder; diabetes; any disorder of the lungs or respiratory system; cancer or immune deficiency disorder (except HIV), AIDS, or AIDS-related complex?	☐	☐
2. Have you or any dependents to be covered visited a health care professional for any illness and/or medical condition resulting in medical expenses more than $5,000 in the past 24 months?	☐	☐
3. Have you or any dependent to be covered been advised in the last 12 months that hospitalization, surgery or treatment is needed or pending?	☐	☐
4. a. Is any female to be covered currently pregnant?	☐	☐
b. If you are a male listed on this enrollment form, are you expecting a child with anyone, even if the mother is not listed on this enrollment form?	☐	☐
5. Does anyone listed on this enrollment form use tobacco products, including cigarette, pipe, cigar, or chewing tobacco?	☐	☐

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE SECTION I BELOW.

I. Health Questionnaire - Details for "Yes" Responses in Sections G and H.

Ques. #: [ ] Name of Applicant: ______________ **Name of Illness/Condition:** ______________
Physician's Name: ______________ Physician's Telephone Number: ( ) ______________
Date of Onset: Month ____ Year ____ Date Treatment Ended: Month ____ Year ____ Still under Treatment: Yes ☐ No ☐
Medication: ______________ Date Prescribed: Month ____ Year ____ Dosage: ______________
Treatment Given:

Ques. #: [ ] Name of Applicant: ______________ **Name of Illness/Condition:** ______________
Physician's Name: ______________ Physician's Telephone Number: ( ) ______________
Date of Onset: Month ____ Year ____ Date Treatment Ended: Month ____ Year ____ Still under Treatment: Yes ☐ No ☐
Medication: ______________ Date Prescribed: Month ____ Year ____ Dosage: ______________
Treatment Given:

Ques. #: [ ] Name of Applicant: ______________ **Name of Illness/Condition:** ______________
Physician's Name: ______________ Physician's Telephone Number: ( ) ______________
Date of Onset: Month ____ Year ____ Date Treatment Ended: Month ____ Year ____ Still under Treatment: Yes ☐ No ☐
Medication: ______________ Date Prescribed: Month ____ Year ____ Dosage: ______________
Treatment Given:

If you are providing additional sheets, check here ☐ and insert the sheets before sealing this Enrollment form.

Conditions of Enrollment *(continued on Page 4)*

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
   - Aetna HMO: Aetna Health of California Inc.
   - Aetna Dental DMO: Aetna Dental of California Inc.
   - Life, disability, dental and all other health coverages: Aetna Life Insurance Company
2. I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both the eligible employee enrollment form and employer applications have been accepted and approved by Aetna. Even if this enrollment form is approved, any misstatements or omissions may result in future claims being denied and the policy or my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes. ***For life coverages:*** I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my

Conditions of Enrollment *(continued from Page 3)*

dependents is also subject to the dependent health condition requirements of the benefit plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent.

3. I understand and agree that this enrollment form may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers"), including pharmacies or pharmacy benefit managers to give to Aetna or its agent information concerning the medical history, prescription history, services or treatment provided to anyone listed on this Enrollment form, including those involving mental health, substance abuse and AIDS or AIDS-related complex. I further authorize Aetna to use such information and to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents, and I have obtained their consent to those terms.
   I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization is valid for thirty (30) months from the date it is signed. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original. The plan may request additional authorizations as may be required by applicable law.
4. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. I understand and agree that, with the exception of Aetna Rx Home Delivery, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
6. I understand and agree that, with certain exceptions described in the plan documents, HMO and DMO plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, primary care dentist, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.
7. I understand and agree that, as described in the plan documents and when enrolled for medical coverage, any pre-existing conditions for my spouse, dependents or myself may not be covered for 6 months.

Misrepresentation

8. Attention California Residents: For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

I represent that all information supplied in this form is true and complete to the best of my knowledge or belief. I have read and agree to the Conditions of Enrollment and Misrepresentation on this California Small Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change Form. I understand that in the event I fail to sign and return this form to my employer within either the open enrollment period or 31 days after eligibility for enrollment or request for coverage change, or if for any reason Aetna does not receive notice of the above transaction request within a reasonable time following eligibility to enroll in or change coverage, my and my dependents' eligibility may be affected.

I am employed by the employer shown on Page 1, and I am working full time at least 30 hours per week or permanent part time at least 20 hours per week for this employer at the regular place of business.

CA HMO ENROLLEES - NOTICE OF BINDING ARBITRATION: ANY DISPUTE ARISING FROM OR RELATED TO HEALTH PLAN MEMBERSHIP WILL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION, AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE AGREEMENT TO ARBITRATE INCLUDES, BUT IS NOT LIMITED TO, DISPUTES INVOLVING ALLEGED PROFESSIONAL LIABILITY OR MEDICAL MALPRACTICE, THAT IS, WHETHER ANY MEDICAL SERVICES COVERED BY THIS AGREEMENT WERE UNNECESSARY OR *WERE UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED.* THE HEALTH PLAN AGREEMENT ALSO LIMITS CERTAIN REMEDIES AND MAY LIMIT THE AWARD OF PUNITIVE DAMAGES. SEE THE EVIDENCE OF COVERAGE FOR FURTHER INFORMATION.

I understand that I am giving up the constitutional right to have disputes decided in a court of law before a jury, and instead am accepting the use of binding arbitration. This means that members will not be able to try their case in court. I further understand that the agreement contains limitations on certain remedies and that there may be certain limitations to the recovery of punitive damages.

Employee Signature	*Spouse Signature*	*Employee E-mail Address (optional)*	*Date (Mo/Day/ Yr)*
X	X		